



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

October 17, 2014

The Honorable Joan Carter Conway  
Chair, Senate Education, Health and  
Environmental Affairs Committee  
2 West, Miller Senate Building  
Annapolis, MD 21401

The Honorable Peter A. Hammen  
Chair, House Health and Government  
Operations Committee  
241 House Office Building  
Annapolis, MD 21401

Re: Review of Services for Medically Fragile  
Foster Care Youth

Dear Senator Conway and Delegate Hammen:

The Department of Health and Mental Hygiene (Department) respectfully submits this report on the review of services for medically fragile foster care youth. The Department initiated this review in response to the death of a child in the care of a provider for medically fragile youth.

As part of this review, the Department's Office of Health Care Quality (OHCQ) reviewed the survey reports and investigations of complaints and self-reported incidents since January 2011 for all four providers serving medically fragile foster care youth. Staff reviewed processes within OHCQ, including initial licensure, re-licensure, triage of self-reported incidents and complaints, survey process, deficiency statements, plans of correction, administrative actions, data management, record keeping, and work flow. Additionally staff reviewed collaboration with other parts of the Department and other agencies. Feedback was solicited from providers, advocacy groups, and other stakeholders.


This review concluded that statutory mandates with respect to the renewal survey frequency every two years were met, and there were no unexpected serious gaps in the oversight of group homes for medically fragile foster care youth. However, several areas for improvement in oversight of these facilities were identified.

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To continue to address those areas for improvement, Bernard Simons, the new Deputy Secretary for Developmental Disabilities, and Patricia Nay, Executive Director and Acting Medical Director of OHCQ, will be convening and co-chairing a task force on the quality of services for individuals with developmental disabilities. The Department of Human Resources will be integrally involved in the parts that relate to services for children in the agency's care. The task force will deliver an initial set of recommendations in January 2015.

If you have any questions about this report of the Department's review, please contact Allison Taylor, Director of Governmental Affairs at 410-767-6481 or at [Allison.Taylor@maryland.gov](mailto:Allison.Taylor@maryland.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Josh M. Sharfstein". The signature is fluid and cursive, with the first name "Josh" being more prominent.

Joshua M. Sharfstein, M.D.  
Secretary

Enclosure

## **Review of Services for Medically Fragile Foster Care Youth**

**Office of Health Care Quality  
Maryland Department of Health and Mental Hygiene  
October 2014**

### **Summary**

As part of an on-going quality process, the Office of Health Care Quality (OHCQ) in the Maryland Department of Health and Mental Hygiene (Department) has reviewed the recent regulatory history of four facilities that provide services to medically fragile foster care youth. The purpose of the review was to identify areas for improvement in oversight.

OHCQ has had multiple contacts with all four providers of care for medically fragile foster children since January 2011. Statutory mandates with respect to the renewal survey frequency every two years were met. This review did not find unexpected serious gaps in the oversight of group homes for medically fragile foster care youth; however, several areas for improvement in oversight of these facilities were identified. Recommendations include:

**Recommendation 1:** OHCQ recommends clarification and documentation of the roles and responsibilities within and between agencies that provide oversight to these providers. Projected date: January 2015

**Recommendation 2:** Each government agency should maximize data point collection for each oversight activity it carries out. An analysis of that data should be shared with other agencies, as appropriate, through formal processes. Projected date: June 2015

**Recommendation 3:** The initial licensure process for programs for medically fragile children should be reviewed and revised to ensure that applicants have a sustainable business model. Projected date: February 2015

**Recommendation 4:** As the lead on investigations of complaints and self-reported incidents, OHCQ should develop formal processes to ensure that coordination with other agencies occurs in a timely and consistent way. Projected date: January 2015

**Recommendation 5:** The children's unit at OHCQ should receive an additional position to serve as a coordinator to implement these recommendations and ensure oversight over the medically fragile children's homes. Projected date: December 2014

To continue progress in this area, Bernie Simons, the new Deputy Secretary of Disabilities, and Tricia Tomsco Nay, Executive Director and Acting Medical Director of OHCQ, will be convening and co-chairing a task force on the quality of services for individuals with developmental disabilities. It is essential that



everyone's voice is heard in this process -- individuals with intellectual and developmental disabilities, family members, friends, advocates, providers, associations, government agencies, legislators, and other stakeholders. The Department of Human Resources (DHR) will be integrally involved in the parts that relate to services for children in the agency's care. The task force will deliver an initial set of recommendations in January 2015.

## **Background**

OHCQ is the agency within the Department of Health and Mental Hygiene charged with monitoring the quality of care in Maryland's 15,043 health care facilities and community-based programs. OHCQ licenses and certifies health care facilities; conducts surveys to determine compliance with state and federal regulations; and educates providers, consumers, and other stakeholders through written materials, websites, and presentations.

In January 2013, the OHCQ implemented a strategic planning process that included an evidence-based review of survey protocols in the context of the statutory and regulatory requirements. One of the broad organizational goals is regulatory efficiency, that is, how to best use OHCQ's limited resources to fulfill its mission.

Interventions for improving regulatory efficiency throughout the agency have included a regulatory and statutory review; revised survey processes, where appropriate; revised initial and on-going employee training; streamlining hiring processes; improving recruitment efforts; streamlining the provider application process; sustaining an internal quality improvement process; interacting proactively with stakeholders and providers; utilization of social marketing; and streamlined and consistent information management processes.

## **Review of Programs for Medically Fragile Children**

In order to provide effective and efficient oversight and ensure the quality of services being delivered, OHCQ completed a focused review of programs for medically fragile children. These programs serve foster care youth who are medically fragile and may require a ventilator and other complex care, as is described in COMAR 14.31.05.03. The providers must meet standards, including consultation by a pediatric medical specialist, special equipment, training for staff in the needs of each child, and emergency medical plans for each child (COMAR 14.31.07.07). Providers in the program for medically fragile children must renew their license every two years (COMAR 14.31.05.06C).

For many years, OHCQ has placed a priority on oversight of providers serving children with developmental disabilities. From 2011 to the present, there have been four providers serving this population: Center for Social Change, Lifeline, Second Family, and Total Quality.

## Methodology

OHCQ staff reviewed the survey reports and investigations of complaints and self-reported incidents since January 2011 for all four providers serving medically fragile foster care youth. Staff reviewed processes within OHCQ, including initial licensure, relicensure, triage of self-reported incidents and complaints, survey process, deficiency statements, plans of correction, administrative actions, data management, record keeping, and work flow. Additionally staff reviewed collaboration with other parts of the Department and other agencies, including Department of Human Resources, Governor's Office for Children, Developmental Disabilities Administration, Medicaid, Office of the Attorney General, and Office of the Inspector General. Feedback was solicited from providers, advocacy groups, and other stakeholders.

## Findings

OHCQ has had multiple contacts with all four providers of care for medically fragile foster children since January 2011 (Table). Statutory mandates with respect to the renewal survey frequency every two years were met. Reviews identified deficiencies at each of the four programs, which providers addressed through corrective actions. When considering the table, consideration must be given to the fact that not all deficiencies are equivalent in scope and severity. Note that Total Quality recently began services and there has only been one survey. In the case of LifeLine, the facility surrendered its license after serious concerns were identified by OHCQ.

	<b>Center for Social Change</b>	<b>Lifeline</b>	<b>Second Family</b>	<b>Total Quality</b>
<b>First OHCQ survey (completed after the first child is placed)</b>	May 2003	December 2000	July 2002	July 2014
<b>Total licensed capacity at all of the provider's sites</b>	14 beds total at 3 sites	15 beds total at 5 sites	53 beds total at 11 sites	3 beds total at 1 site
<b>Licensure status as of September 2014</b>	Active	No longer licensed	Active	Active
<b>Number of deficiency statements from January 2011 – August 2014</b>	4	4	5	1
<b>Number of deficiencies from January 2011 – August 2014</b>	33	42	113	4
<b>Number of deficiencies from January 2011 - August 2014 per licensed capacity</b>	2.4	2.8	2.1	1.3

The table below summarizes the eleven most frequently cited deficiencies in these children's programs from January 2011 to August 2014. Seven tags involved lack of documentation of required training, two tags involved requirements for emergency drills, one tag involved lack of documentation of the outcome of a children's protective service check, and one tag involved behavior plans that were incomplete or not up to date.



Tag	# of Times Cited from 1/2011 – 8/2014	Description
Y2335	6	No documentation of the required 40 hours of initial training
Y2380	6	No documentation of training in discipline and behavior management techniques
Y2405	6	No documentation of training in special needs of the population
Y3160	6	No documentation that emergency drills were held monthly
Y2390	5	No documentation of annual infection control training
Y3175	5	No documentation that emergency drills included emergencies other than fires
Y4795	5	Behavior plan was not current or was incomplete
Y2275	4	No documentation of the outcome of a children's protective services check
Y2370	4	No documentation of training in child abuse and neglect
Y2395	4	No documentation of training in parenting issues, collaboration with families, and supporting children and families
Y2400	4	No documentation of training in psychosocial and emotional needs of children, family relationships, and separation

The next sections of this report examines specific areas of oversight, including opportunities for improvement.

#### General Responsibilities

Oversight of group homes for medically fragile foster care youth involves various methods by multiple agencies. While the system needs some redundancies to avoid missing important issues, unnecessary duplication leads to inefficiency. Historically, the Developmental Disabilities Administration issues the license. OHCQ conducts relicensure surveys and investigates complaints and self-reported incidents. The Department of Human Resources (DHR) provides payment and monitors these providers through quarterly visits from its licensing coordinators. Each month, DHR caseworkers also see the youth assigned to them who are placed with these providers. The agencies share information to coordinate the oversight of the services delivered to this medically fragile population.

In monitoring the quality of care and delivery of services, there are many potential red flags: poor performance on a relicensure survey, financial instability, administrative concerns, increased number and/or severity of complaints, and significant deviation in the number of self-reported incidents. Using information from multiple sources, OHCQ investigates the provider and cites noncompliance with regulations. A deficiency report is issued and the provider must complete and submit an acceptable plan of correction to the agency. If indicated, administrative actions may be imposed for serious noncompliance with the regulations.

Not every red flag is a predictor of current or potential system failures in a provider. For instance, a provider facing bankruptcy may provide high quality care until the last day of service. Conversely, a provider with the largest profit margin in their industry may be providing poor quality care. While financial instability and other concerns may be a red flag, each situation is unique and must be examined in the larger context of available information.

This review has found that while front line staff between agencies communicate frequently, processes for communication and role definition can be better delineated. Greater clarity in the roles, processes, and procedures will ensure that agencies provide coordinated oversight. This is particularly important as the State has an aging workforce. At OHCQ, fifty-one percent of the staff are eligible for retirement now or within five years. As new employees retire and individuals assume new roles, it is crucial that processes, policies, and procedures are well documented to ensure clear transitions. Process description and documentation also provides an opportunity for reassessment to determine how to most efficiently and effectively conduct oversight of these providers.

**Recommendation 1:** OHCQ recommends clarification and documentation of the roles and responsibilities within and between agencies that provide oversight to these providers. Projected date: January 2015.



## Data Management

The Department's ability to collect and analyze data is limited by software, technology, and time. While OHCQ staff have the ability to analyze the data in meaningful ways to enhance the quality of oversight services, the above limitations prevented the agency from doing so routinely in the past. OHCQ oversees the quality of care in 15,043 providers and issues tens of thousands of deficiencies each year. There are multiple systems that track large amounts of data, but unfortunately not all of these systems can communicate with each other. Some tracking is still done manually or on a Microsoft Excel spreadsheet.

Early in 2013, OHCQ began utilizing software licensed to OHCQ by the Centers for Medicare and Medicaid Services for the developmental disabilities unit. Improving record retention, data point collection, and data retrieval will center on maximizing use of the powerful software. Moving forward, this will facilitate data management and survey activities in the unit. Additional benefits of this transition will be seen over the next year as the software is more fully implemented.

Maximizing existing technology to increase staff efficiency and effectiveness and planning for future technology is essential to all agencies involved in oversight. OHCQ is engaged in an ongoing process of making more data points, documents, and agency findings accessible in its comprehensive software for tracking all its licensees. However, this work is developing outside of potential coordination with others.

**Recommendation 2:** Each government agency should maximize data point collection for each oversight activity it carries out. An analysis of that data should be shared with other agencies, as appropriate, through formal processes. Projected date: June 2015

## Initial Licensure Process

There are many steps in the current initial licensure process to ensure that applicants are equipped to provide quality services in a sustainable business model; however, the administrative challenges that were later identified as facing Lifeline, Inc. has identified opportunities to strengthen the licensure process for this and other provider types. OHCQ, DHR, and DDA have many areas of expertise, but their staff are not expert at reviewing business plans, assessing the sustainability of financial models, and identifying fraud and abuse.

Provider solvency and liquidity can impact continuity of care. Application for a new license should require documentation that demonstrates a sound business plan and capital to provide and sustain the care described in the program service plan. The content of the application that would demonstrate acceptable financial preparedness is best determined by state agencies with expertise in this area.

However, the potential for financial strain to impact continuity of care makes the business plan a critical component to initial licensure.

The importance of tightening up the initial licensure process is paramount in our long-term ability to serve this population. This has countless benefits downstream for all parties involved. Investment of time and effort on the front end helps to ensure quality services are provided in a sustainable model.

**Recommendation 3:** The initial licensure process for programs for medically fragile children should be reviewed and revised to ensure that the applicant has a sustainable business model. Projected date: February 2015

### Investigations of Complaints and Self-Reported Incidents

Complaints and self-reports are potential red flags that a provider may not be adhering to sound processes or may identify faulty processes. It is crucial that these potential problems are promptly triaged and investigated, as indicated, to ensure the quality of the services being delivered. Investigations are done on-site or through administrative reviews, as appropriate.

After review of the provider's incident report, many self-reports do not require any further action. Others may require coordination with other state and local agencies, including DHR, Governor's Office for Children, DDA, Children's Protective Services, and law enforcement. While this happens through communication at a staff level, there is a need for a more formal documentation of this process.

**Recommendation 4:** As the lead on investigations of complaints and self-reported incidents, OHCQ should develop formal processes to ensure that coordination with other agencies occurs in a timely and consistent way. Projected date: January 2015

### OHCQ Staffing

OHCQ employs three full-time staff to oversee quality in 17 group homes that provide services to medically fragile foster care youth. While this staff has been able to conduct required inspections and review complaints and self-reports, it is not sufficient for the full range of planning, policy review and revision, and interagency coordination needed. Additional human resources are needed to review and revise the plans contemplated by the other recommendations and establish an improved oversight process.

**Recommendation 5:** The children's unit at OHCQ should receive an additional position to serve as a coordinator to implement these recommendations and ensure oversight over the medically fragile children's homes. Projected date: December 2014



## Conclusion

This review did not find unexpected serious gaps in the oversight of group homes for medically fragile foster care youth. Relicensure surveys were conducted with the required frequency and complaints and self-reports were triaged and investigated. However, the review did find multiple areas for improvement. Some of these lessons that we learned are applicable to other provider types. System improvement will require the active involvement of stakeholders associations, and advocates and that the agencies be transparent with them about process improvement efforts. By unnecessarily decreasing the administrative burdens of providers; simplifying processes; implementing evidence-based changes to the survey process; enhancing training and technical assistance; and optimizing data analysis; we can better ensure quality for individuals receiving services.

With limited resources, we must focus our skills on the timely investigation and resolution of complaints and self-reported incidents to best protect individuals. There is a need for on-going strategic planning and quality improvement processes that continually examine each agency's efficiency and effectiveness. Through these actions, we can create a system that will better protect the health and safety of individuals with intellectual and developmental disabilities throughout Maryland.

## Moving Forward

OHCQ has applied the lessons learned from this and other reviews to other provider types, including those serving adults with developmental disabilities. Lasting system improvement requires an on-going commitment to a quality improvement process based upon a collaborative inter-agency strategic plan including widespread accountability. The Department is committed to such a process rather than quick fixes, unattainable assurances, or uncoordinated actions among multiple agencies.

Bernie Simons, Deputy Secretary of Disabilities, and Tricia Tomsco Nay, Executive Director and Acting Medical Director of OHCQ, will be convening and co-chairing a task force on quality oversight of services for individuals with developmental disabilities. It is essential that everyone's voice is heard in this process -- individuals with intellectual and developmental disabilities, family members, friends, advocates, providers, associations, government agencies, legislators, and other stakeholders. DHR will be integrally involved in the parts that relate to services for children in the agency's care. The task force will deliver an initial set of recommendations in January 2015. Though we look at the issues through different perspectives, it is only through our combined efforts that we will succeed in enhancing the quality of services for individuals with developmental disabilities.